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Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
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The Dialogue

A QUARTERLY TECHNICAL ASSISTANCE BULLETIN ON DISASTER BEHAVIORAL HEALTH

CALL FOR INFORMATION

The Dialogue is an arena for professionals in the disaster behavioral health field to share information, resources, trends, solutions to problems, and accomplishments. Readers are invited to contribute profiles of successful programs, book reviews, highlights of State and regional trainings, and other news items. If you are interested in submitting information, please contact Catherine Johnson at catherinej@esi-dc.com.

JOIN *THE DIALOGUE* DISCUSSION BOARD

Do you have a question you would like to share with fellow disaster behavioral health coordinators? Are you frustrated with thwarted efforts of collaboration with other agencies or organizations? Have you found a resource you think others might find useful in planning?

Send your questions and responses to *The Dialogue* Discussion Board, dtac@esi-dc.com, and we will include your comments and queries in the next issue (Winter 2006). Help us make this an effective method of communication for the field.

Our last discussion topic was: How have you collaborated or provided disaster behavioral health services to tribal communities in your State/Territory? What have been some of your successes or challenges?

Please see the feature article in this issue of The Dialogue *on White Bison, a nonprofit organization that provides mental health resources to Native Americans.*

Our next discussion topic is: What do you see as the intermediate and long-term mental health needs of the evacuees from Hurricanes Katrina and Rita?

SAMHSA's Hurricane Response

The catastrophic impact of Hurricanes Katrina and Rita and the resulting evacuations are engendering a disaster behavioral health response that is unprecedented in size and scope in this country. In addition to the devastation directly experienced in the Gulf Coast States, the Federal Emergency Management Agency (FEMA) registrant data indicates that every State and several Territories have accepted evacuees, with many States having evacuees numbering in the hundreds and even thousands.

A debt of gratitude is due to countless members of the disaster behavioral health community at the Federal, State, and local levels who have tirelessly donated their time and expertise in responding to these tragic hurricanes and their aftermath. Disaster behavioral health plans across the country have been activated. Responders have been deployed to meet the needs of survivors in the Gulf States and those who were evacuated, leaving behind family members, pets, and personal possessions. As the immediate response is still occurring, it is becoming clear that the long-term mental health and substance abuse needs will be substantial with new needs emerging throughout the reconstruction period.

SAMHSA has been actively responding to the behavioral health needs caused by the hurricanes. SAMHSA's mission for responding to Hurricanes Katrina and Rita, in collaboration with State, local, and Federal partners, is to:

- Ensure that mental health and substance abuse assessments and crisis counseling are readily available to residents and evacuees of impacted areas and establish a long-term plan to assure posttraumatic stress disorder (PTSD) is addressed with this population.
- Ensure that people impacted by the hurricanes who have serious mental illnesses and/or addictive disorders, and children with serious emotional disturbances continue to receive ongoing treatment for their chronic disorders.

Hurricane response activity undertaken by SAMHSA and its partners to date includes:

- Developing a Web site dedicated to hurricane response efforts. The Web site is called SAMHSA's One Stop Shop for Hurricanes Katrina and Rita Resources and may be accessed via the following link: http://www.samhsa.gov/hurricane/default.asp.
- Activating the SAMHSA Emergency Response Center (SERC) to serve as a point of contact for all State mental health and substance abuse authorities, as well as all Federal agencies and local mental health providers. The SERC is part of the National Response Plan and is the coordinating body for the overall Federal response for mental health and substance abuse issues for Hurricanes Katrina and Rita.
- Partnering with FEMA to facilitate the application process for Crisis Counseling Assistance and Training Program (CCP) funding to support the crisis counseling efforts in the Gulf Coast States as well as for States and Territories that have accepted evacuees.
- Collaborating with the American Red Cross and other voluntary and faith-based organizations active in disaster to help ensure that the crisis counseling, grief counseling, and other immediate mental health and substance abuse services needs are met.
- Deploying mental health and substance abuse services professionals to the impacted Gulf Coast States to provide

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services to survivors and public safety workers as well as to consult with State and local leadership on disaster behavioral health service delivery, incident command, and program implementation.

- Promulgating the SAMHSA Suicide Prevention Hotline, 1-800-273-TALK, as a resource for hurricane survivors and their care providers. The hotline is connected to a network of local crisis centers and mental health and substance abuse providers across the country.
- Expediting the approval of funding for SAMHSA Emergency Response Grants to provide immediate assistance to Louisiana, Alabama, Mississippi, and Texas.
- Providing technical assistance, disaster behavioral health materials, and deployment of a cadre of consultants to hundreds of disaster behavioral health stakeholders across the country through the SAMHSA Disaster Technical Assistance Center (DTAC).
- Working with partners at the National Child Traumatic Stress Network (NCTSN) and the National Center for Post-Traumatic Stress Disorder (NCPTSD) to provide States with the critical information and resources needed to serve the behavioral health needs of children and families.

As the aftermath of the hurricanes unfolds, additional needs will undoubtedly surface requiring additional resources—both for survivors in the Gulf Coast region and in States/Territories where evacuees are being housed. SAMHSA will continue to work with the partners at the Federal, State, and local levels to identify and help to address the mental health and substance abuse needs arising from the disasters.

For additional up-to-date information, please visit the following Web sites:

- http://www.samhsa.gov/huricane/default.aspx
- http://www.mentalhealth.samhsa.gov/dtac
- http://www.fema.gov

Rural Crisis Counseling: One Perspective

Many of us have our own personal definitions of rural life. Some may see the rural lifestyle as romantic while others may hold onto a long-standing stereotype depicting backwardness. What these definitions, positive or negative, have in common is a disregard for the complexities and subtleties that exist in all rural areas.

Someone who has never lived within a rural area might see these populations as fairly homogeneous. To the contrary, traditions and cultures in rural America vary widely from town to town as well as from farm to town. Prior to establishing a rural crisis counseling program, it is critical that the team of workers be well acquainted with the "cultural geography" of the area they will be serving. One must keep in mind the adage, "landscape shapes mindscape." In addition, the guiding principle, "seek first to understand, then be understood" should serve as a foundation for any successful rural crisis counseling program.

On a good day, rural mental health may be less attended to than urban mental health, but mental disorders are at least as prevalent in rural areas as in urban areas, and may be higher for substance abuse, depression, suicide, and traumatic stress.

Rural living can present challenges for many individuals. Poverty, older populations, access difficulties, lack of privacy, and isolation are integral aspects of rural life. Rural life is reflected in such characteristics as self-reliance, conservatism, a distrust of outsiders, religion, work orientation, emphasis on family, individualism, and fatalism. One must have an understanding of the pervasive effects poverty has on a person's mental health if they are to become an effective crisis counselor/outreach worker.

There is hesitancy within rural populations to seek outside help as this is often seen as a sign of failure. There are numerous reasons for this: The historical culture of self-sufficiency; the lack of anonymity; not knowing what services are available; and the fact that available models are based on urban experiences and lack the flexibility for farm/rural needs.

> *Rural America is home to a fifth of the Nation's people, keeper of natural amenities and natural treasures, and safeguard of a unique part of American culture, tradition and history, comprising more than 2,000 counties and 75 percent of the Nation's land.*
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> Source: The U.S. Department of Agriculture's Economic Research Service.

RURAL CRISIS COUNSELORS MUST MEET CLIENTS WHERE THEY LIVE

Long before I became involved in disaster relief work I learned a valuable lesson concerning mental health work with rural families. As a home-based services counselor, I was assigned to work with an adolescent female and her farming family following her discharge from an inpatient treatment facility. My work was in a rural farming community in northern Minnesota.

During my first visit, I was met by the girl's mother and led into the living room where I joined the identified patient, her siblings, and her mother. Her father was conspicuously absent. When I left from this initial meeting, I spied him looking at me as he loaded bales of hay into his pickup truck. This situation repeated itself over the course of the next few meetings. I believed that if the family was going to make any progress dad's participation would be critical.

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One rainy fall afternoon an opportunity presented itself which changed the course of the family work. As I approached the ½-mile driveway, I noticed the father running across the road in pursuit of his dairy herd that had broken the fence to feed on a neighboring pasture. I intuitively knew that this was my opportunity to draw this man into the counseling process.

I pulled out a pair of boots from behind my pickup seat and joined him as he trudged through the mud to gather up his herd. I followed his lead and relied on his expertise. After an hour we had his cows back in the barn. At that point, he followed me into the farmhouse and we began family counseling in earnest.

Although crisis counseling is not therapy, I use this story to illustrate the resistance often encountered when offering assistance to rural families. In this particular case I was keenly aware of what my presence meant to this proud farmer. The fact that another man was showing up at his doorstep to assist his family could mean only one thing in his mind: He had failed. Lesson learned. In order for this dad to join me in my world…I first had to join him in his.

OVERCOMING RESISTANCE WITH "CULTURAL BROKERS"

The positive aspects of rural self-sufficiency and individualism can quickly become a liability in the face of disaster. This sense of pride may cause rural citizens to respond more slowly to assistance than their urban counterparts. It is this delayed response that calls for an active, creative crisis counseling outreach model. Rural crisis counselor teams need to represent the populations they serve.

The hiring of indigenous paraprofessionals is the key to successful interventions in rural disaster areas. The term "cultural broker" is used frequently to describe individuals who, with relative ease, carry the message of hope and recovery to various groups within a community. These workers have the ability to cross cultural lines and translate mental health concepts into common, everyday language. They carry with them a sometimes forgotten trait—the trait of simply being a good, caring neighbor. These workers understand their role is not to "fix" people. Rather, they are there to offer practical support, education, and normalization. Above all else, they must convey unconditional positive regard for those they serve.

Following an F3/F4 tornado that cut a 40-mile path across northwestern Wisconsin in June 2001, a FEMA crisis counseling program was quickly established to assist the impacted rural communities. Twenty individuals were hired who represented a cross section of the communities to be served. There were four master's-level mental health workers and a retired psychologist, all of whom lived within the service delivery area. These professionals had many years of collective experience and understood the importance of setting aside traditional mental health approaches.

Just as important, however, was the enlistment of qualified paraprofessionals. These individuals knew their communities well and had the natural ability to listen to others. This team consisted of a pastor, teacher, school guidance counselor, nurse, town board chairman, volunteer firefighter, newspaper reporter, small business owner, retired farmer, and other community members (both from the villages as well as from the country). Each team member brought a different perspective to the group and had unique ways of accessing particular populations. We welcomed this wide variety of community knowledge and expertise when establishing our intervention strategies. In essence, they represented different "cultures": Faith-based culture, school culture, medical culture, local government culture, first responder culture, media culture, business culture, farming culture, village culture, country culture and second-home-owner (vacationer) culture. In a sense, we were a microcosm of the larger community. We had to learn to cooperate and build on one another's strengths.

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THE ART OF CRISIS COUNSELING

Rural crisis counseling programs call for no-nonsense, compassionate, practical approaches. Successful programs are those that weave their way into community life. Team members know the emotional pulse of the communities they serve and are actively involved in community recovery. Partnering with schools, places of worship, service organizations, the business community, government agencies, and mental health and substance abuse providers ensures that the message of hope and recovery becomes a community-wide message. The most effective interventions are subtle. So subtle at times, that those on the receiving end may not even know that they have been counseled.

Six months into our tornado recovery, a grief workshop was offered to the community. Following a day-long training for the crisis counselors, a regional expert on grief and loss was scheduled to make a presentation to the community. Three people attended. We had to rethink our approach if we were to attract wounded community members.

In planning the event, we simply overlooked how a predominately Scandinavian population tends to grieve losses. Grief in this community is quite private. A public setting is not a place where rural folks will talk about their wounds. The crisis counselors had to weave a different scenario to get to the grief without threatening the participants. We were reminded of the importance of offering practical assistance.

The tornado leveled 60,000 acres of mature forestland. The collective grief over the loss of these trees was very real. The landscape of our region has been altered for the remainder of most of our lives. With this in mind, we contacted a Department of Natural Resources ranger and a landscaper and created a Tree Forum. We redesigned the evening to offer people information concerning the planting of new trees—a how, when, and where event. Two hundred people attended. Over the course of the night, our counselors simply circulated and listened to survivors' stories. Local churches offered coffee and rolls. In the process, all shared their grief without ever calling it that. Those who felt alone in their loss were reminded that many others shared similar feelings. It was an evening filled with hope and promise despite the devastation that engulfed us. The term "mental health" was not mentioned.

It is this sort of creative process that distinguishes the crisis counseling process from other forms of "psychological assistance." This work breathes spirit back into dispirited lives and communities. In essence, this process helps survivors remember what they already know—that we all need help sometimes. There is something quite human about asking for it as well as offering it.

> *It seemed that the most valuable therapy we were providing had nothing to do with antibiotics and wound care. By listening to story after heartbreaking story, admiring pictures of families once happy and healthy, and playing soccer with children who lost everything, we were able to say, 'We care about you and share in your grief,' without speaking a word.*
>
> Source: Rebecca O'Connor, pediatric nurse, referencing her work in the Sri Lanka Tsunami relief effort.

Although there is a universal human hunger for emotional support when one is thrown into a crisis, it behooves us to "know the land upon which we tread," before reaching out to others. Rural culture differs from urban culture. We are much better equipped as crisis counselors, and serve survivors more effectively, when we take this into consideration.

This article was contributed by Gil Hoel, licensed clinical social worker and certified alcohol and drug counselor in Wisconsin.

White Bison Offers Healing Resources to Native Americans

White Bison is an American Indian nonprofit organization based in Colorado Springs, CO. Through White Bison, its Founder and President Don Coyhis, Mohican Nation, has offered healing resources to Native America since 1988. White Bison offers sobriety, recovery, addictions prevention, and wellness learning resources to the Native American community nationwide. Many non-Native people also use White Bison's healing resource products and attend its learning circles.

White Bison is a proud facilitator of the "Wellbriety" movement (Wellbriety means to be sober and well). Wellbriety teaches about sobriety from addictions to alcohol and other drugs and recovery from the harmful effects of drugs and alcohol on individuals, families, and whole communities. The "Well" part of Wellbriety is the inspiration to go beyond sobriety and recovery, committing to a life of wellness and healing every day.

White Bison's mission is to assist in bringing 100 Native American communities into healing by 2010. This mission is being realized by means of the many Wellbriety resources, conferences, specialized community training events, coalitions, and the popular grassroots Firestarters circles of recovery groups across the country.

White Bison collaborates with the following coalitions, networks, and organizations in an effort to provide a voice for Native Americans in recovery and healing:

SAMHSA Center for Substance Abuse Treatment (CSAT); SAMHSA Center for Substance Abuse Prevention (CSAP); September National Alcohol and Drug Addiction Recovery Month; Recovery Community Support Program (RCSP); Johnson Institute National Recovery Movement Planning Committee; National Institute on Alcohol Abuse and Alcoholism (NIAAA); National Drug Prevention League; National Association of Children of Alcoholics (NACOA); National Association of Native American Children of Alcoholics (NANACOA); Community Anti-Drug Coalitions of America (CADCA); and September Annual Circles of Recovery Conference.

For more information on White Bison, go to http://www.whitebison.org.

Conducting Research in Diverse, Minority, and Marginalized Communities

As the disaster behavioral health field advances, studies that carefully assess the full mental health and psychosocial impact of disasters continue to play a crucial role. Disaster preparedness, policy development, and allocation of resources all rely to some degree on such assessments. A book in press, *Research Methods for Studying Mental Health after Disasters and Terrorism*, (Norris, F., Galea, S., Friedman, M., & Watson, P.), addresses these issues. One chapter, by Russell T. Jones, Ph.D., and colleagues, examines ways to remedy the lack of adequate disaster mental health research in minority communities. Presented courtesy of Dr. Jones and summarized below, "Conducting Research in Diverse, Minority, and Marginalized Communities" offers a glimpse at this upcoming publication.

In this chapter, Jones identifies gaps in the trauma literature as it relates to diverse populations, ethnic minorities, and marginalized communities. He emphasizes the need for more systematic and quantitative studies by researchers in the disaster mental health field that will produce data to inform audiences on intervention modalities that are culturally, racially, and ethnically sensitive.

Jones identifies gaps in the trauma literature as it relates to diverse populations, ethnic minorities, and marginalized communities.

Jones justifies the need for this research through the following factors: Post-disaster samples have included insufficient numbers of people of color and marginalized communities; the prevalence of trauma among people of color and marginalized communities; and the hypothesis that these groups are at greater risk following disaster. Jones notes the psychosocial, socioeconomic, physiological, and psychological factors that should be taken into account by researchers studying the trauma-related impact on vulnerable populations. Also noted is the need to include variables such as race, gender, social support, parental functioning, and coping mechanisms following traumatic events.

Of significance is Jones' examination of race-related stressors that include intra-psychic, social, and economic effects of racial prejudice or stigmatization, as well as bicultural identification. He notes that these may be essential in the discovery of linkages between risk factors and symptom expression. Treatment efficacy with such groups is also of special concern as it remains an under-researched area to include clinical trials, psychotherapy, and cognitive-behavioral therapy.

Jones identifies three pertinent barriers that researchers face to gain entrée into marginalized communities, including: Minorities' fear and lack of trust; access; and culture and linguistics. Jones emphasizes the long-standing historical implications of African-Americans' distrust of the scientific community dating back to the Tuskegee Studies. Also of importance is the fear of Latino immigrants to participate in research because of concerns of deportation. In addition to the factors mentioned above, marginalized communities and ethnic minorities may be particularly difficult to access due to stigma, as well as the need to take time away from work to talk with researchers.

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Jones notes cultural and linguistic competence as significant barriers in the researchers' attempt to access marginalized communities. The researcher must be attuned to variables such as understanding, appreciation of constructs of thought, values, customs, and beliefs held by those within multiple ethnic and/or racial groups. Language has also proven to be a major barrier when conducting research with diverse groups. Research clearly indicates the disparity of ethnic minorities receiving mental health services due to the lack of bilingual mental health workers. Jones also notes the overwhelming amount of research instruments that rely on the English language, which also decreases their validity with various ethnic and racial groups.

Jones concludes his chapter with a proposed model for enhancing the trauma researchers' ability to address the aforementioned issues titled Cultural Competence Model for Accessing Minority and Marginalized Communities Impacted by Disaster. With cultural competency as the overarching principle of this model, it is viewed as a vehicle to increase access to quality care for all patient populations, and as a business strategy to attract new patients and market share. Jones argues that researchers in the disaster behavioral health field must take the following steps through a culturally competent lens if further research among disasters and marginalized communities is to occur. The researcher must assess and discuss levels of distrust, involve community gatekeepers, and be able to articulate the benefits of the research to the community members. Researchers and clinical staff must admit that there is a "problem" and know that avoidance as a classic response to trauma coupled with the obstacles that already exist among ethnic minorities present special circumstances. Researchers should also forge rapport and relationships within such populations and communities.

Research clearly indicates the disparity of ethnic minorities receiving mental health services due to the lack of bilingual mental health workers.

Jones remarks on the importance of including diverse local, State, and national stakeholders as well as having "key players of color" during the planning process in order to build a culturally competent model. The focus on relationship building between researchers and diverse members of the community from laypeople to professionals is essential. In addition, Jones recommends a collaborative approach to community-based research in which studies are conducted in community settings utilizing active participation of its members in the research process. He cites Israel, Schultz, Parker, & Becker (1998) who state that this approach builds on the strengths and pre-established networks that exist within the community. Secondly, it creates a collaborative partnership between researchers and community members in which ownership of the studies is created. Also of importance is that this type of community-based research allows for the partnerships of individuals with diverse skills that are valuable in solving complex problems addressed by community-based research designs.

As previously mentioned, Jones cites access to diverse, minority, and marginalized populations and cultural and linguistic barriers as constraints to community-based research with such groups. A number of practical suggestions to gaining entrée with these populations are offered by Jones, some of which include using publicity campaigns, door-to-door recruitment, providing transportation to research sites, incentives for participation and importantly, providing information regarding the study as well as the relative benefits to the community. The use of indigenous professionals, paraprofessionals, and

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community leaders may help to ease the mistrust often held with marginalized populations. Researchers must not only follow a model of cultural competence, but also be attuned to the linguistic challenges faced.

The use of indigenous professionals, paraprofessionals, and community leaders may help to ease the mistrust often held with marginalized populations.

Jones cites several recommendations to aid the disaster researcher in this area including:

- Training and education on linguistic-appropriate service delivery;
- Interpreter services and use of bilingual members at no cost to the participants;
- Inclusion of culturally and linguistically competent measures and assessments; and
- A written plan developed by the research team that outlines goals, policies, and systems of accountability to engage culturally competent services.

In conclusion, this chapter sheds light on the gross under-representation of disaster research studies targeting diverse, ethnic minorities, and marginalized populations. He identifies barriers and offers practical solutions based on sound validated models that use a "lens" of cultural competence necessary for disaster researchers to employ. Jones' work sheds light on gaps in disaster research literature that must be addressed if research studies are to be representative of all populations.

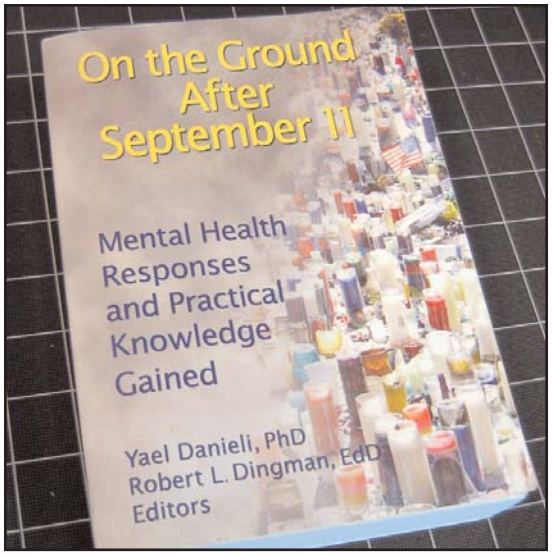
Russell T. Jones, Ph.D., is a clinical psychologist and professor of psychology at Virginia Tech.

SUGGESTED READING LIST

Have you discovered a useful planning document or resource? Or, have you read an interesting book, column, or journal article that you would like to share? Following are three recent suggestions, one with a book review:

- **Ace Collins. (2003).** *Tragedies of American History: 13 Stories of Human Error and Natural Disaster.* This is a collection of extraordinary moments from America's past. Ace Collins tells the real-life tales of men, women, and children trapped in situations beyond their control. Culled from documents, interviews with key participants, and news stories of the day, *Tragedies of American History* chronicles the harrowing human drama of individuals facing life at its most extreme. From the Galveston Hurricane of 1900 to the Coconut Grove Fire of 1942, from the Great Nashville Train Wreck of 1918 to 1953's Waco Tornado, here are the famous as well as the forgotten events that illustrate America's strength in the face of overwhelming circumstances.
- **Centers for Disease Control and Prevention, Office of Communication. (2005).** *Crisis and Emergency Risk Communication by Leaders for Leaders.* Viewed September 22, 2005 at **http://www.cdc.gov/communication/emergency/blfl.pdf.** Seven leaders detail key emergency risk communication principles to follow during an event in the face of a major public safety emergency.
- **On the Ground After September 11: Mental Health Responses and Practical Knowledge Gained. (2005).** *Yael Danieli, Ph.D., & Robert L. Dingman, Ed.D. (Eds.).* See book review.

Book Review



On the Ground After September 11: Mental Health Responses and Practical Knowledge Gained. (2005). *Yael Danieli, Ph.D., & Robert L. Dingman, Ed.D. (Eds.).*

The growing field of disaster behavioral health has a powerful new resource based on the mental health impact and lessons learned in the wake of the terrorist attacks of September 11, 2001. Yael Danieli and Robert Dingman's (Eds.) *On the Ground After September 11: Mental Health Responses and Practical Knowledge Gained* offers a well-rounded view of the efforts many mental health and other human service programs undertook in response to this tragedy. More than a collection of informative essays detailing traditional mental health responses, *On the Ground* calls on a wide variety of professional, paraprofessional, and personal experiences. Psychologists, social workers, public health workers, disaster mental health planners, teachers, spiritual leaders, artists, and those who lost loved ones lend their voices to this informative and moving publication.

Several essays deal directly with the mental health challenges that arose after 9/11 and how programs were developed to meet those needs. Neal Cohen, commissioner of both New York City departments of health and mental health at the time of the attacks, writes about the response strategies employed. Populations were prioritized according to their proximity to the attacks. Social support networks were mobilized, and the recognition that all New Yorkers were directly affected allowed for an extremely broad outreach and public education campaign.

An essay by two military psychiatrists who were on the scene at the Pentagon highlights the importance of providing critical support and monitoring the effects of trauma over time. Their direct work moved them to develop a model of "relationship-based intervention" titled "therapy by walking around." Using a developmental model, they followed trauma victims over time, monitored the effects of trauma, and recognized that their vulnerabilities may change. This approach allowed staff to give trauma victims the right kind of support when they needed it the most. Eventually, this work led to the creation of the Operation Solace Program.

On the Ground dissects disaster mental health by reminding us of one of this field's fundamental premises, i.e., nurture resilience in those who have been exposed to horrible events. An excellent account detailing the success of a family counseling center is given. It describes eight core philosophies that allowed it to respond to families' traumatic grief with flexibility and a wide range of services. Some contributors also examine resiliency from community-wide and law-enforcement perspectives.

Many contributors examine the emotional impact of 9/11 on special communities. The unique challenges for people with disabilities are examined as well as lessons learned in developing disability components of disaster mental

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health programs. Other special populations addressed include first responders, the elderly, children, holocaust survivors, and those with prior trauma experiences.

Stirring personal accounts infuse this book with intensely human emotions and reflections.

Volunteers rushed to the scenes for weeks after 9/11 and played crucial roles as caregivers. Several essays look at issues impacting volunteers such as the importance of volunteer self-care and factors affecting volunteer coping. One contributor, an American Red Cross volunteer assigned to the Family Assistance Center on Pier 94, kept a journal of his emotional 10-day experience. He offers his own personal reflections on the appropriateness of maintaining eye contact with family members and respecting families' spirituality. When challenged by language barriers or when helping people from different cultures, he fell back on the universality of touch, a simple smile, or by being "fully present."

Stirring personal accounts infuse this book with intensely human emotions and reflections. These first-hand revelations are interspersed throughout and bring a balanced touch to the tales of disaster behavioral health response.

Some speak of loved ones lost, lives forever changed, or the challenge to experience beauty and resilience in their post-9/11 worlds. Some contributors describe how their experience as a Muslim influenced their participation in recovery efforts or how they faced prejudice and discrimination. Works, such as Ami Orava's poignant poem 9/11/01, round out the human perspective of this tragedy.

So what are the lessons learned? They are contained in the challenges overcome, the personal resolve found, and the collaboration described within these accounts. The field of disaster mental health has come a long way over the past decade. Brian W. Flynn, Ed.D., summarizes lessons learned in the epilogue when he writes, "Between the lines of this book is the mandate that we better integrate service, research, training, and policy development." Clearly, *On the Ground* achieves its goal as a witness, both deeply moving and informative, to how a multitude of organizations and individuals sought to help heal the human spirit during the most difficult of times.

Upcoming Meetings

2005 ISTSS ANNUAL MEETING DISSEMINATION: TRANSFORMING LIVES THROUGH TRANSFORMING CARE

NOVEMBER 2–5, 2005
TORONTO, CANADA

In the past decade, we have learned a great deal about recovery following traumatic events and the helpfulness of interventions for those with persistent trauma-related disorders like PTSD. However, as professionals working with trauma survivors on a daily basis, and as those who are personally recovering from the effects of trauma, many of us are keenly aware of some basic but unfortunate facts regarding care for trauma survivors.

Many trauma survivors, despite suffering considerable trauma-related difficulties, do not seek care for years following the trauma. Still others, when they ultimately seek help, find that there are few available resources in their communities. And finally, for others, when they find available help, they do not get access to state-of-the-art care.

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The focus on dissemination suggests work to "spread widely" the knowledge gained through years of systematic research and accumulated experience. This focus is intentionally broad and includes: Translational research; bridging the gap between basic research and clinical practice; and research that builds on efficacy questions such as, "Does it work?" to begin to address effectiveness questions such as, "What works for whom and under what circumstances?"

In addition, dissemination addresses topics with broad public health implications such as: How and when to utilize early interventions to help prevent chronic problems in both military and civilian populations; a systematic study of dissemination methods themselves; how to facilitate trauma survivors seeking help after traumatic events; what kind of interventions are preferred; how to best enhance access to services in remote locations where helping professionals are rare; and how to best train providers of mental health services (professionals, lay people, and graduate students) to provide quality, state-of-the-art care. For more information, go to: http://www.istss.org/meetings/.

AMERICAN PUBLIC HEALTH ASSOCIATION: 133RD ANNUAL MEETING & EXPOSITION

DECEMBER 10–14, 2005
PHILADELPHIA

The APHA Annual Meeting & Exposition is the premier public health educational forum. Learn from experts in the field, hear about cutting-edge research and exceptional best practices, discover the latest public health products and services, and share public health experiences with peers. The world of public health is in continual motion, and there is no better time to stay abreast of the research and learn about emerging issues.

The APHA Annual Meeting & Exposition is the oldest and largest gathering of public health professionals in the world, attracting more than 13,000 national and international physicians, administrators, nurses, educators, researchers, epidemiologists, and related health specialists. APHA's meeting program addresses current and emerging health science, policy, and practice issues in an effort to prevent disease and promote health.

The 2005 APHA Annual Meeting & Exposition theme, Evidence-based Policy and Practice, explores the processes of systematically finding, appraising, and using scientific research as the basis for developing sound practices. The knowledge gleaned from this research is used to develop policies and practices that improve health outcomes and performance as well as allowing for more efficient use of resources. Policy makers are also provided with a better understanding of the science, ensuring that policy decisions are based on the best information available. For more information, go to: http://www.apha.org/meetings/index.htm.